November 9, 2006

The National Press Club Symposium Report

www.veteransnationalsymposium.org

Voices for Action:

A Focus on the Changing Needs of America's Veterans

national symposium for the

NEEDS OF YOUNG VETERANS

HOSTED BY AMVETS

Voices for Action:

A Focus on the Changing Needs of America's Veterans

national symposium for the

NEEDS OF YOUNG VETERANS

HOSTED BY AMVETS

November 9, 2006

First Edition

national symposium for the
NEEDS OF YOUNG VETERANS
HOSTED BY AMVETS

Issues Committee
Sub-Committee on Healthcare

Overview

A covenant exists between all military/veterans (active duty, Rerserve, Guard components) and America, a binding agreement that also includes family/dependents care. While additional focus has been placed on this in recent years, much more needs to be done. Benefits to families in several areas are inadequate or nonexistent. These include pre/post-deployment education, family deployment support, health insurance issues, legal support and education. Therefore, our mission is to develop recommended health related (and other) policy changes to address inadequacies and/or non-existent health related programs that will affect positive change for future active and reserve service members.

Long-term care is defined as a commitment to care over a lifetime, using a holistic approach including consideration of spiritual needs, mental care, physical issues, recreation and overall quality of life for all veterans and family. Care must include an age-appropriate plan to deal with disabilities and ailments associated with environmental exposures (known and unknown) and duties performed during military service. The goal of this care is to provide and enable the highest level of functioning and independence for all veterans, in or near their communities.

The basic diagnosis of Post Traumatic Stress Disorder, as listed in the "Diagnostic and Statistical Manual for Mental Disorders" (DSM-IV) is "The person has been exposed to a traumatic event in which both of the following were present: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and (2) the person's response involved intense fear, helplessness, or horror." The DSM-IV may be found at http://omi.unm.edu/PTSD-DSM-IV.html.

While Post Traumatic Stress Disorder (PTSD) is a chronic condition, it can go into remission with the person functioning in a normal manner for a long period of time. Many signs and symptoms (red-flags) are ignored or not understood. PTSD should not automatically disqualify service members from status of duty. Treatment and/or management should be provided to service members/veterans to encompass problems. Many service members, veterans and family members are unaware of the programs currently available.

The estimated population of women veterans as of 2001 was 1.6 million, or about 7.2 percent of the total veteran population. 10.26% of the 22.8 million veterans who use VA for healthcare are women. Currently, women make up 14.8 percent of the active duty military force and approximately 22.8 percent of the Reserve force. By 2010, they are expected to represent over 14 percent of the total veteran population. Fifty-six percent of women veterans who use VA are less than 45 years of age. Sixty-two percent of women veterans are less than 45 years of age.

Dependent's Assistance

1. Custodial laws are inadequate and insufficient.
2. Healthcare and Insurance Systems are complex and inadequate.
3. Dependents must be recognized throughout the entire military cycle.
4. When a unit deploys, the dependent's life changes dramatically.

Hospital and Compensation & Pension Examination Appointment Backlog

5. Lack of Customer Service.
6. Gross misappropriation/non-uniformity of funding throughout DVA.
7. Lag between time appointment made and when appointment info entered into system, affecting 30-day limit.
8. Current categories of care are not equitable.

9. Delay of care due to new specialty conditions (i.e. depleted uranium/anthrax vaccine).
10. Two-year priority is not long enough for GWOT veterans.

Long Term care

11. Inadequate funding for VA healthcare.
12. Access to care.
13. Means of care.

Post Traumatic Stress Disorder: Combat Veterans

14. Services; there are gaps and inconsistencies in the continuum of services (including peer support) for the range of readjustment and stress-related reactions for veterans.
15. Preparation and Prevention; there are gaps and inconsistencies in PTSD prevention programs across the armed services, including pre-deployment education to prepare people psychologically for combat.
16. Women veterans with PTSD are underserved. Current modes of treatment do not address the particular reintegration issues facing women, including the challenges of providing childcare and the exacerbating effects of violence, sexual harassment, or sexual assault they may have experienced while in the military.
17. Stigma; many veterans do not seek help or treatment, and there is a lack of self-reporting. Because discrimination against veterans who seek help or treatment is a reality, veterans worry that acknowledging PTSD and related mental health issues may affect their military or post-military careers.
18. Access; there is confusion among veterans on how to find and access services. In addition National Guard andReserve veterans may require services before returning to drill 90 days after the end of deployment.
19. Outreach; there is a disconnection between the needs of veterans and their families and the services available to them. This often includes difficulty in simply locating those no longer on active duty. Under the traditional system, veterans must seek out help. Different groups may, or may not, be contacting them wanting to provide services (e.g. DVA, VHA, non-profit organizations, county services, etc.)
20. There is a lack of education, across the board, including civilian/military sectors and families.
21. There is a lack of proper/appropriate support/follow-up networks/groups.

Post Traumatic Stress Disorder: Women in Combat and Sexual Trauma

22. Inadequate funding to support current and future women veteran healthcare issues.
23. Lack of pre-, during-, and post-deployment education tools and support to service members and their families.
24. Service members are not being enrolled in the VA system.
25. Post-deployment briefings are ineffective.
26. Lack of a central referral agency.
27. Sexual trauma/sexual harassment can cause Post Traumatic Stress Disorder.

Quality of Care and Staff Attitudes

28. Information/latest news not being disseminated to VAMCs/clinics.
29. Seamless Transition is not consistently available throughout VAMCs and military installations.
30. Inadequate follow-up with medical/mental health.
31. Sensitivity to veterans' needs.

Vocational Rehabilitation

32. Lack of knowledge of some internal/external services.
33. Lack of critical staff.
34. Veterans do not understand what Vocational Rehabilitation can offer.
35. Stigma associated with VA.
36. Community lack of awareness of VA purpose and services..

Issue 1
Custodial laws are inadequate and insufficient

Recommendation

Family law needs to protect the Veteran's custodial rights (similar to the provisions of the Soldier and Sailor act), before, during, and after deployment. This will require changes to 50 USC 501 through 596.

Rationale

The Service Members Civil Relief Act of 2003 (Title 50, United States Code, Sections 501 through 596) amended the Soldiers and sailors Civil Relief Act of 1940 in order to provide for, strengthen, and expedite the national defense through protection extended by this Act to service members of the United States to enable such persons to devote their entire energy to the defense needs of the Nation. The Act should be amended to include service members immediate family (spouse and/or children) the same protections as those granted the service member. Additionally, the Act should include provisions to protect the service member and/or spousal custodial rights as pertaining to dependents under the age of consent.

Issue 2
Healthcare and Insurance Systems are complex and inadequate.

Recommendation

Establish a special custodial ID card for non-dependent spouses with children who are military dependents. This will require changes to Department of Defense Instruction 1000.13.
Care for family of wounded servicemen. Housing and travel should be provided. This is an action item for the Department of Defense.
TRICARE, in general, needs to be seamless and less complex and affordable. This is an action item for the Department of Defense.
Steering Committee Note: The Steering Committee appreciates the work and effort expended by the members of the Health Care work groups. Although we will look at the following areas from time to time in the future, at this point we do not intend to pursue them as we feel the recommendations listed below have been resolved. Amplification is included in the rationale.

Expand TRICARE network through mandate and provide reimbursement at Medicaid/Medicare levels.

Affordable and accessible healthcare for all service member families.

Establish a full time position with unit/group to address dependent support.

Easy access to TRICARE where dependents can get a clear answer to their questions.

Train the trainers. As a means to bring disciplines together for the purpose of disseminating information.

Steering Committee Note: This following recommendation is covered in detail under work groups specific to Vocational Rehabilitation.

Educate Vocational Rehabilitation and better funding.

Rationale

There are many occasions where, in the event of divorce, the civilian spouse of the service member receives custody of the dependent children. The children retain their dependent's identification card, but the spouse does not. A special custodial ID card would allow the spouse to enter the military installation for purposes of seeking health care for the children and shopping for the children's needs. Currently a dependent's ID card may be issued to un-remarried and unmarried former spouses, however, when the spouse remarries the ID card must surrendered.

Steering Committee Note: Title 10, USC, Section 1079(h)(1) states "Except as provided in paragraphs (2) and (3), payment for a charge for services by an individual health care professional (or other non-institutional health care provider) for which a claim is submitted under a plan contracted for under subsection (a) shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). The Secretary of Defense shall determine the appropriate payment amount under this paragraph in consultation with the other administering Secretaries."

Steering Committee Note: "Active duty: Active duty service members (ADSM) are required to be enrolled in Prime. Coverage is automatic, but the service member must fill out and submit an enrollment form. Active duty family members: Many other beneficiaries choose to enroll in Prime-particularly active duty family members (ADFM). For ADFMs enrolled in Prime, there are no enrollment fees, deductibles, or co-payments. ADFMs must take action to enroll-that is, complete and submit an enrollment form to the regional contractor, one for each family member." (http://www.tricare.osd.mil/tricareprime/who-is-eligible.cfm).

Steering Committee Note: This program is currently available through the following sources: Army Family Liaison Office; Navy Services Family Line; USAF Combat Support and Community Services; Marine Corps Family Services; Coast Guard Ombudsman; Army National Guard Family Readiness Program; Army Reserve Family Program; Navy Reserve Ombudsman Online; Air Force Reserve Family Readiness; Marine Corps Reserve Community Services; Coast Guard Reserve Member, Family, and Employer Support; and other programs located at http://deploymentlink.osd.mil/deploy/family/family_support.shtml.

American Trans Air provides free travel for immediate family members of active duty US military personnel convalescing in any US hospital due to injuries suffered during military action in Iraq. This includes immediate family members attending funeral services of US military personnel killed during the conflict in Iraq. Continental Air Lines, Delta Air Lines, and United Air Lines offer discounted flights, worldwide. DOD provides a travel entitlement for service members and their families in serious medical emergencies. Additionally, the Army Emergency Relief Society, Navy-Marine Corps Relief Society, and the Air Force Aid Society may provide loans or grants to cover unexpected expenses. This information may be located at http://www.dod.mil/mapcentral/specialaid.html. Transportation authorization for dependents of hospitalized US military personnel is available and authorized in accordance with The Joint Federal Travel Regulations, Volume I, Chapter 7, Paragraph U7205. However, this regulation is, at best, unclear.

Steering Committee Note: TRICARE lists, at http://www.tricare.osd.mil/contactus/, 11 toll-free telephone numbers for various health care topics and eight additional toll-free numbers for general information based on the service member's or dependents' residence location.

TRICARE offers a number of different types of plans. TRICARE Prime is an HMO type of program which is provided at no cost to active duty personnel and their dependents. This program has a premium rate of $200 per annum for the military retiree and/or $400 per year for the military retiree and his/her dependents. TRICARE Extra allows those eligible personnel who are not enrolled in TRICARE Prime or TRICARE for Life to see a TRICARE Prime network provider. TRICARE Extra does have a deductible and a co-payment. The co-payment is generally 5% less than that of TRICARE Standard. TRICARE Standard is a fee-for-service plan that allows the beneficiary to see any medical professional they choose. It has an annual deductible, a co-payment, and may require the patient to file the necessary claim forms. TRICARE for Life is similar to TRICARE Standard, but is limited to those beneficiaries who are eligible for Medicare due to age, end stage renal disease, or disability. It requires the beneficiary to enroll in Medicare Part B.

Issue 3
Dependents must be recognized throughout the entire military cycle.

Recommendation

Establish a toll-free number for regional representative knowledgeable about military, VA, and TRICARE healthcare programs. This is an action item for the Department of Defense.

Provide incentive for dependent participation in educational forum. This is an action item for DOD.

Steering Committee Note: This following recommendation, phrased differently, has been incorporated into Issue 2 recommendations.

National Team: Create and maintain a National Level Resource Center (speakers, literature) on basic dependent issues. Use of technology would allow for widest dissemination.

Rationale

Although there are, as described under Issue 2, a number of sources for information of this sort, there may not be a single source that a dependent may contact. The DOD has the capability of mandating this mission to those groups listed in Recommendation 4 to Issue 2.

Issue 4
When a unit deploys, the dependent's life changes dramatically.

Recommendation

Outreach to the community to educate civilian component. This is an action item for DOD.

Mandated regular contact between rear detachment units and family readiness groups. This is an action item for DOD.

Rationale

In a number of alleged cases this issue is either not handled at all or it is mishandled. Although the DOD can direct its activities to outreach with the civilian community, it cannot compel the civilian community to participate. This is a prime example of why it is so important for the garrison or installation commander to develop a relationship with the local civilian leadership. This relationship should include local area mayors and city councils, the local chamber of commerce, and other civic organizations. Most installation commanders do this as a normal routine.

Not all units, especially in thesea services, have a rear area detachment during the unit's deployment. It is imperative that the unit Ombudsman serve as a liaison between the family Readiness Groups and the dependents of unit members.

Issue 5
Lack of Customer Service.

Recommendation

Increase Staff. This is an action item for the Department of Veteran Affairs subject to budgetary constraints.

Provide results of the current survey to Hospital Directors. This is an action item for the Department of Veterans Affairs.

Rationale

The FY 2007 Budget Submission for DVA requested an increase of $3.3 billion for Medical Care, $1.6 billion of that is earmarked for ambulatorycare. Additionally the budget submission requested authorization/funding to hire an additional 100 physicians, 100 non-physician providers, and 415 health technicians/allied health professionals.

The 2001 National Veteran Survey is available on the DVA web site at http://www1.va.gov/vetdata/page.cfm?pg=5. The Symposium survey will be placed on the National Symposium on the Needs of Young Veterans Web site by the end of November.

Issue 6
Gross misappropriation/non-uniformity of funding throughout DVA.

Recommendation

Divide earmarked healthcare funding. This is an action item for the Department of Veterans Affairs.

Rationale

Once the Congress approves, and the President signs, the DVA Budget the following normally occurs. Funds are divided, at the direction of the Under Secretary for Health with the concurrence of the Deputy Secretary of Veteran Affairs, as delineated within the budget package. Within each budgeted area the funds are divided up by Veterans Integrated Service Network (VISN) to be utilized for the specified programs at facilities so earmarked by the VISN Director.

Issue 7
Lag between time appointment made and when appointment info entered into system, affecting 30-day limit.

Recommendation

Vet leaves provider's office with next scheduled appointment in hand. This is an action item for the Department of Veteran Affairs.

Rationale

The governing directives are Veterans Health Administration Directives 2006-028 and 2006-055. These directives specify that an appointment must be scheduled within 7 calendar days of receiving the request from the patient or the provider. Appointments are to be scheduled within 30 days of the date requested for service-connected disabled veterans rated at 50% or more and for other service-connected disabled veterans being treated for their service-connected disabilities. All other appointments will be set within 120 days of the date requested.

Issue 8
Current categories of care are not equitable.

Recommendation

Set a national standard for all regions. This is an action item for the Department of Veterans Affairs.

Rationale

The Department of Veteran Affairs has been directed by the Congress, under Title 38 United States Code Section 1705, to divide veteran enrollees into eight priority groups.
(1) Veterans with service-connected disabilities rated 50 percent or greater.
(2) Veterans with service-connected disabilities rated 30 percent or 40 percent.
(3) Veterans who are former prisoners of war or who were awarded the Purple Heart, veterans with service-connected disabilities rated 10 percent or 20 percent, and veterans described in subparagraphs (B) and (C) of section 1710 (a)(2) of this title.
(4) Veterans who are in receipt of increased pension based on a need of regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled.
(5) Veterans not covered by paragraphs (1) through (4) who are unable to defray the expenses of necessary care as determined under section 1722 (a) of this title.
(6) All other veterans eligible for hospital care, medical services, and nursing home care under section 1710 (a)(2) of this title.
(7) Veterans described in section 1710 (a)(3) of this title who are eligible for treatment as a low-income family under section 3(b) of the United States Housing Act of 1937 (42 U.S.C. 1437a (b)) for the area in which such veterans reside, regardless of whether such veterans are treated as single person families under paragraph (3)(A) of such section 3 (b) or as families under paragraph (3)(B) of such section 3 (b).
(8) Veterans described in section 1710 (a)(3) of this title who are not covered by paragraph (7).

These Priority Groups are for enrollment only. Treatment priorities are set up differently. This prioritization is Service-Connected Disabled Veterans rated 50% or more; Service-Connected Disabled Veterans rated 40% or less who are being treated for their service-connected disabilities, and all other veterans. However, urgent or immediate care over rides all other considerations.

Issue 9
Delay of care due to new specialty conditions (i.e. depleted uranium/anthrax vaccine).

Recommendation

Steering Committee Note: The Steering Committee appreciates the work and effort expended by the members of the Health Care work groups. Although we will look at the following area from time to time in the future, at this point we do not intend to pursue at as we feel the recommendations listed below have been resolved. Amplification is included in the rationale.

Create hotline, Web site for education on these specialty conditions.

Rationale

Steering Committee Note: There is a Gulf War veterans Web site located at http://www1.va.gov/health/clinical.html. This web site includes information on programs that affect those veterans who served in Desert Shield, Desert Storm, OIF. Depleted Uranium, Anthrax Vaccine and Botulinum Vaccine information are included. The hotline telephone number is 1 (800) PGW-VETS.

Issue 10
Two-year priority not long enough for GWOT veterans.

Recommendation

Steering Committee Note: The Steering Committee appreciates the work and effort expended by the members of the Health Care work groups. Although we will look at the following area from time to time in the future, at this point we do not intend to pursue it as we feel the recommendations listed below have been resolved. Amplification is included in the rationale.

Extend time beyond current two years for combat veterans, after date of discharge. (Current law says it is not date of discharge, but date you arrive back in CONUS).

Rationale

Steering Committee Note: Public Law 105-368 [Title 38 USC 1710(d)(D)] authorizes VA to provide combat veterans cost-free care for conditions potentially related to their combat service for up to two years following their discharge or release from active duty. These veterans will be enrolled into Enrollment Priority Group 6 if not otherwise qualified for a higher enrollment priority group assignment. VA provides full access to the Medical Benefits Package by virtue of this enrollment status. Additionally, once the two-year period has expired, the GWOT veteran may enroll just as any other veteran.

Issue 11
Inadequate funding for VA healthcare.

Recommendation

VA funding should be based on level of troop commitment. This is an action item for the Congress.

VA should have flexibility to move funds between appropriations to meet program needs. This is an action item for Congress and the Office of Management and Budget.

Mandated programs should be funded. This is an action item for Congress.

Rationale

Traditionally, Congress has not associated the need to adequately fund VA Health care as a responsibility associated with sending men and women to war. As we have seen in the resent combat and VA budget shortfalls, one of the last considerations of any US engagement in war or conflict has been the human toll extracted from the men and women who defend this nation. Funding for the care and rehabilitation of our veterans has not been directly linked to the appropriations allocated to VA. It is clear from recent shortfalls that levels of funding need to be directly linked to the tasks assigned to the Armed Forces of our Nation. Estimates of casualties and disabled veterans are included in war planning; therefore it is a logical assumption that funding for health care should be included in any commitment of troops to combat areas.

The baseline formula for VA funding should be directly proportional to the levels of troop commitment. Before entering into any war, the government should include funding for Veteran Benefits and Health care. When Congress authorizes any new VA benefits, services or programs, there must be and increase in the budget to un-funded mandates to veterans programs are unacceptable and should be eliminated.

Issue 12
Access to care.

Recommendation

Mandatory enrollment of service member in VA health care upon return from deployment/discharge.

VA must have more flexibility to provide care needed by veterans; not institutional care.

VA staff and Leadership should focus on the changing needs of veterans.

Rationale

Service members do not always have thorough and comprehensive physical examinations upon discharge from the military or return from deployment which makes documentation of illnesses, disabilities or injuries incurred as a result of their military

service difficult to document. Family members, who are the primary care givers for severely disabled veterans need to be educated about options for care, expectations for rehabilitation and included in plans for care. Additionally, veterans are unaware of how to access VA services and programs, their options for care and the disability rating system which is poorly defined and difficult to understand. In many respects, VA remains an institutional model of care which lacks the adaptability and flexibility to provide for veterans who are able to live in the community instead of being consigned to nursing homes. Young veterans foresee that the effects of Service Connected Disabilities will change and become more complicated as they age.

All service members should be automatically enrolled in the VA healthcare program upon their return from deployment and/or release from Active Duty. Medical records should be automatically forwarded to the VA with the permission of the veteran. Most importantly, upon demobilization, all service members should receive a copy of their medical records and be required to be debriefed by a healthcare professional. A federal standard is needed for all military post-deployment health reassessments.

The VA must have the flexibility to bring whatever care is needed to the veterans, instead of forcing veterans to come to the care. Mobile medical teams should be provided for homeless and home care veterans.

The prohibition against publicizing VA services to the general public should be ended. Community education and advertisement projects should be promoted and amended and funded to better inform veterans and their families about VA healthcare and options for services and programs.

An online service should be established to allow veterans to input their specific needs and receive program recommendations in return. This service should offer orientation information as well as detailed briefings by qualified personnel. This Web site should be continuously updated.

VA staff and leadership should focus on the changing needs and expectations of young veterans that differ from the majority of veterans in the VA system. Standards for quality of life, interests and aspirations for levels of activity including the utilization of new medical technologies.

Issue 13
Means of care.

Recommendation

Military retirement and severance pay should be separate from VA disability pay.

Establish comprehensive care management for veterans with multiple chronic issues.

Overhaul the entire 1945 schedule of rating disabilities.

Allow family to play an active role in all treatment and care management.

Rationale

The "Seamless Transition" needs to be more personalized with more emphasis at the local levels. Modern warfare takes a different kind of toll on service members' physical needs. Traumatic brain injuries are now one of the signature injuries of current combat operations and polytrauma injuries are increasingly common. Young veterans expressed concern about the long term effects of injuries sustained in combat and some of the immunizations and/or medications they were required to take before and during deployments. Specifically mentioned were: a) lack of knowledge about infertility problems related to modern equipment both in the short- and long-term and b) multiple orthopedic injuries which are also likely to become more complex over the life of a veteran. VA is seen as an "old soldiers" care system which has not geared up to meet the needs of younger veterans. Approaches to providing VA health care needs to include the expectations and rehabilitation goals cherished by troops coming home today.

Despite great strides, VA is not perceived as being prepared for the increasing numbers of female veterans who are serving in combat areas.

Families of veterans are often not included in the planning of care or properly educated on all available options. This education tends to occur retroactively after relevant decisions have been made. The veteran and the families of the veteran are the decision makers regarding care issues, and should be treated as such. The VA must fulfill its responsibility to enable

them to make informed decisions. Every member of the medical treatment team is obligated to assist in educating family and veteran about choices for care.

A comprehensive study should be commissioned to explore long-term health issues related to modern warfare. This study should focus on the emerging needs of young veterans, especially women veterans, and provide information to guide VA to design health care services which are timely, appropriate and effective.

Disability compensation must keep pace with the severity of the injuries sustained and the level of sacrifice endured by young veterans. The policy tying VA disability pay to severance pay from the military, results in reduced payments to injured veterans. Military retirement and severance pay should be separate from VA disability pay. Further, employment should be seen as an important aspect of the rehabilitation process and should not reduce the amounts of compensation paid to Service Connected Veterans.

There is no intermediate means of care between outpatient treatment and permanent nursing home residence. Appropriate services, including long-term care, should be established especially for veterans with catastrophic illness and polytrauma injuries. Benchmarks must be published for polytrauma care so veterans and their families know what is available and what options exist. Case/care managers should be assigned to assist veterans and their families with care and support issues. They should act as a personal concierge to the veterans and their families to assure that proper care is provided in a timely manner without hassles.

Issue 14
Services; there are gaps and inconsistencies in the continuum of services (including peer support) for the range of readjustment and stress-related reactions for veterans.

Recommendation

The continuum of services must extend from prevention through treatment and follow-up, and intervention must occur as early as possible. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs.

The continuum of services must include DOD, DVA, community mental health, individual practitioners, non-profit organizations, and other providers, both nationally and locally. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs as well as state departments of veterans affairs and local mental health boards.

There must be support groups for service members who do not present symptoms until later, potentially months or years after combat. This is an action item for the Department of Veterans Affairs and the Veterans Service Organizations.

Spirituality must be a component of the continuum of care. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs as well as state departments of veterans affairs and local mental health boards.

Continuum of services must include those who do not meet the diagnostic criteria for PTSD. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs.

The collaboration between DOD and DVA must address the gaps and inconsistencies in programs for families and must include state and local communities. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs.

DOD, DVA, community mental health, individual practitioners, both nationally and locally, need to be educated about the commonalities and differences between PTSD and TBI symptoms. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs as well as state departments of veterans affairs and local mental health boards.

Community based providers must be educated regarding the unique concerns of military experience. This is an action item for the Department of Veterans Affairs as well as state departments of veterans affairs and local mental health boards.

Rationale

There are many different types of individuals suffering from PTSD. This is not just a problem for combat veterans, but for first responders, battered wives and children, victims of sexual trauma, witnesses to events such as the attack against the World Trade Center on September 11, 2001, etc. Unfortunately, the media, in many cases, has tagged it as a combat veteran issue. In

fact, many journalists who have been on the scene of traumatic events may also suffer from this illness.

Unfortunately, when dealing with emotional or mental health issues, the underlying cause(s) is (are) not readily apparent. Although there are a number of recommendations our participating veterans would like to see implemented, we are fortunate in that the majority of the PTSD experts in this country, either are or were, employed by the US Department of Veteran Affairs.

The Department of Veteran Affairs maintains a list of resources for those returning from deployment including information for active duty, Reservists, and National Guard members and their families at http://www.ncptsd.va.gov/facts/veterans/fs_resources_for_vets.html.

The Iraq War Clinician Guide was developed by members of the National Center for PTSD and the Department of Defense. It was developed specifically for clinicians and addresses the unique needs of veterans of the Iraq war. It may be found at http://www.ncptsd.va.gov/war/guide/index.html.

Issue 15

Preparation and Prevention; there are gaps and inconsistencies in PTSD prevention programs across the armed services, including pre-deployment education to prepare people psychologically for combat.

Recommendation

There must be more research, evaluation, and implementation of evidence-based prevention programs. This is an action item for the Departments of Defense, Homeland Security, and Veteran Affairs.

There must be consistency in coping skills and resiliency training. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs.

Rationale

Treatment for PTSD typically begins with a detailed evaluation and the development of a treatment plan that meets the unique needs of the survivor. Generally, PTSD-specific treatment is begun only after the survivor has been safely removed from a crisis situation. If a survivor is still being exposed to trauma (such as ongoing domestic or community violence, abuse, or homelessness), is severely depressed or suicidal, is experiencing extreme panic or disorganized thinking, or is in need of drug or alcohol detoxification, it is important to address these crisis problems as a part of the first phase of treatment.

It is important that the first phase of treatment include educating trauma survivors and their families about how persons get PTSD, how PTSD affects survivors and their loved ones, and other problems that commonly come along with PTSD symptoms. Understanding that PTSD is a medically recognized anxiety disorder that occurs in normal individuals under extremely stressful conditions is essential for effective treatment.
Exposure to the event via imagery allows the survivor to re-experience the event in a safe, controlled environment, while also carefully examining his or her reactions and beliefs in relation to that event.

One aspect of the first treatment phase is to have the survivor examine and resolve strong feelings such as anger, shame, or guilt, which are common among survivors of trauma.

Another step in the first phase is to teach the survivor to cope with post traumatic memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Trauma memories usually do not go away entirely as a result of therapy but become manageable with the mastery of new coping skills.

Issue 16

Women veterans with PTSD are underserved. Current modes of treatment do not address the particular reintegration issues facing women, including the challenges of providing childcare and the exacerbating effects of violence, sexual harassment, or sexual assault they may have experienced while in the military.

Recommendation

There must be flexibility in PTSD programs for women, including the option of gender- specific programs. This is an action item for the Department of Veterans Affairs.

There must be the same consistency in availability of services for women that exists in men. This is an action item for the Department of Veterans Affairs.

Rationale

During and after the Vietnam War, mental-health professionals and behavioral scientists began to notice adjustment problems in some veterans returning from Southeast Asia. At first, these problems were characterized as a "post-Vietnam syndrome." In 1980, this condition was officially recognized by the American Psychiatric Association as Post Traumatic Stress Disorder, or PTSD.

The National Vietnam Veterans Readjustment Study (NVVRS) is the only national study of Vietnam veterans that included women. Of the 1,632 Vietnam veterans in the study, 432 were women veterans who had served in or around Vietnam sometime between 1964 and 1975. Most of these women were registered nurses, and 90% had been commissioned officers. Over half had served more than four years in the military, and about one-fifth had served 20 years or more. At the time of the National Vietnam Veterans Readjustment Study, about 45% of these women were married; less than half had children.

The National Vietnam Veterans Readjustment Study found that approximately 27% of women Vietnam veterans suffered from PTSD sometime during their postwar lives. Over the last few years, researchers at the National Center for PTSD have been looking further into the information collected in the NVVRS. One part of their research work has been to determine how factors other than war-zone experiences might be related to the severity of PTSD.

They have found that high levels of social support after the war played an important role for women. Those women who reported that they had friends and family available to them were less likely to have symptoms of PTSD. In particular, emotional support - having someone to talk to and someone who really cares - helped women to adjust more comfortably to postwar life. It was also important for the returning women veterans to feel that they could rely on others to assist them with tasks in times of need. Veterans who had this form of support also suffered less from PTSD

Issue 17

Stigma; Many veterans do not seek help or treatment, and there is a lack of self-reporting. Because discrimination against veterans who seek help or treatment is a reality, veterans worry that acknowledging PTSD and related mental health issues may affect their military or post-military careers.

Recommendation

There must be better education regarding mental health issues from the top down. Veterans and leaders must be informed that there are different types and levels of PTSD and that there is hope for recovery and return to duty. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs as well as state departments of veterans affairs and local mental health boards.

The stigma associated with PTSD and related mental health issues must be addressed as a command/leadership issue. There must be anti-discriminatory regulations. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs.

A position of unit liaison must be established, trained, and knowledgeable about PTSD to facilitate the needs of the individual service member. This is an action item for the Departments of Defense and Homeland Security.

Rationale

PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.

PTSD is associated with a number of distinctive neurobiological and physiological changes. PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdala. Both the hippocampus and the amygdala are involved in the processing and integration of memory. The amygdala has also been found to be involved in coordinating the body's fear response.

Psychophysiological alterations associated with PTSD include hyper-arousal of the sympathetic nervous system, increased sensitivity of the startle reflex, and sleep abnormalities.

People with PTSD tend to have abnormal levels of key hormones involved in the body's response to stress. Thyroid function

also seems to be enhanced in people with PTSD. Some studies have shown that cortisol levels in those with PTSD are lower than normal and epinephrine and norepinephrine levels are higher than normal. People with PTSD also continue to produce higher than normal levels of natural opiates after the trauma has passed. An important finding is that the neurohormonal changes seen in PTSD are distinct from, and actually opposite to, those seen in major depression. The distinctive profile associated with PTSD is also seen in individuals who have both PTSD and depression.

PTSD is associated with the increased likelihood of co-occurring psychiatric disorders. In a large-scale study, 88 percent of men and 79 percent of women with PTSD met criteria for another psychiatric disorder. The co-occurring disorders most prevalent for men with PTSD were alcohol abuse or dependence (51.9 percent), major depressive episodes (47.9 percent), conduct disorders (43.3 percent), and drug abuse and dependence (34.5 percent). The disorders most frequently co-morbid with PTSD among women were major depressive disorders (48.5 percent), simple phobias (29 percent), social phobias (28.4 percent), and alcohol abuse/dependence (27.9 percent).

PTSD also significantly impacts psychosocial functioning, independent of co-morbid conditions. For instance, Vietnam veterans with PTSD were found to have profound and pervasive problems in their daily lives. These included problems in family and other interpersonal relationships, problems with employment, and involvement with the criminal justice system. Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, and discomfort in other parts of the body are common in people with PTSD. Often, medical doctors treat the symptoms without being aware that they stem from PTSD.

In order to maintain a higher degree of readiness among our combat proven service members, medical personnel assigned to all branches of the military, including Public Health Service providers attached to the Coast Guard, should be trained in recognizing, assessing, and treatment of PTSD. Additionally, unit or installation medical officers need to either serve as the unit's liaison dealing with the service member, the family, and the command staff.

Issue 18

Access; there is confusion among veterans on how to find and access services. In addition National Guard and reserve veterans may require services before returning to drill 90 days after the end of deployment.

Recommendation

The military must establish a better model for ongoing veteran support, including regular contacts over time. This is an action item for the Departments of Defense and Homeland Security.

Peer mentors must be trained concerning stress and PTSD and function as unit liaisons to identify those at risk and to provide referral and resource information. This access must be confidential. This is an action item for the Departments of Defense and Homeland Security.

Rationale

VA Medical Centers and Vet Centers provide veterans with mental-health services. Additionally county mental health boards, private practice therapists, and military treatment facilities are all sources of treatment for the service member or the veteran. Information on finding providers, what to look for in a provider, and the different types of providers may be found at http://www.ncptsd.va.gov/facts/treatment/fs_seeking_help.html.

Issue 19

Outreach; there is a disconnection between the needs of veterans and their families and the services available to them. This often includes difficulty in simply locating those no longer on active duty. Under the traditional system, veterans must seek out help. Different groups may, or may not, be contacting them wanting to provide services (e.g. DVA, VHA, non-profit organizations, county services, etc.)

Recommendation

Require sexual assault response coordinator to brief service members during down time prior to deployment at mobilization sites. This is an action item for the Departments of Defense and Homeland Security.

Ensure a certified unit representative in the field is present. This is an action item for the Departments of Defense and Homeland Security.

Medical evidence of the incident should be provided to the service member. This is an action item for the Departments of Defense and Homeland Security.

Rationale

The Department of Defense does not tolerate sexual assault and has implemented a comprehensive policy that reinforces a culture of prevention, response and accountability that ensures the safety, dignity and well-being of all members of the Armed Forces. Our men and women serving throughout the world deserve nothing less, and their leaders-military and civilian-are committed to maintaining a workplace environment that rejects sexual assault and attitudes that promote such behaviors.

Sexual assault response coordinators are available at most military installations and may be located via service branch links at the USDOD Sexual Assault Prevention and Response at http://www.sapr.mil/.

Issue 20

There is a lack of education, across the board, including civilian/military sectors and families.

Recommendation

Develop and implement a community-based (civilian/military) PTSD awareness program that familiarizes individuals on the warning signs, symptoms, and available treatment options. Utilize the mass media outlets to establish this goal. PTSD is treatable, just like any other condition. This is an action item for the Departments of Defense, Homeland Security, and Veteran Affairs as well as state departments of veteran affairs and local mental health boards.

Rationale

Information provided by the USDOD Sexual Assault Prevention and Response website at http://www.sapr.mil/ and the web site of the National Center for Post Traumatic Stress Disorder at http://www.ncptsd.va.gov/index.html should both be utilized in this process. Another site that will provide excellent resource materials is the American Psychological Association at http://www.apa.org/.

Issue 21

There is a lack of proper/appropriate support/follow-up networks/groups.

Recommendation

Developing grassroots-level veterans groups to assist in the appropriate network. Provide training and support for groups established. This is an action item for the Department of Veterans Affairs and the Veterans Service Organizations.

Rationale

Every VetCenter operated by the DVA offers support groups and follow-up networks. There are 207 VetCenters located in every state, the District of Columbia, Guam, Puerto Rico, and the US Virgin Islands. Additionally, many of the Veteran Service Organizations offer these programs as well, the Vietnam Veterans of America, in particular, offers some excellent support groups at local chapters throughout the country.

Issue 22

Inadequate funding to support current and future women veteran healthcare issues.

Recommendation

Every VA Medical Facility should have a full-time woman veteran's program manager, mental health manager, and family therapist for immediate family members. This is an action item for the Department of Veterans Affairs.

Rationale

VA has responded to the growing number of women veterans by targeting programs to meet their unique health-care needs.
A Veterans Health Administration office to address women's health issues was first created in 1988.
Every VA Medical Center has a Women Veterans Program Manager who is available to assist women veterans.
Public Law 102-585, Veterans Health Care Act of 1992, authorized new and expanded services for women veterans, including counseling for sexual trauma on a priority basis. VA is committed to assist women veterans with a wide range of mental health and psychosocial services. The services include sexual trauma counseling, substance abuse treatment, and evaluation and treatment for Post Traumatic Stress Disorder (PTSD), which includes women veterans Stress Disorder Treatment Teams. In addition, there are programs for homeless women veterans, victims of domestic violence, and Vocational Rehabilitation.

Public Law 102-585 in 1992 authorized VA to include outreach and counseling services for women veterans who experienced incidents of sexual trauma while serving on active duty in the military. The law was later amended and authorized VA to provide counseling to men as well as women. The Veterans Millennium Health Care and Benefits Act of 1999 extended the provision of counseling and treatment services to veterans who have experienced military sexual trauma through December 31, 2004.
In fiscal year 1997, the Under Secretary for Health appointed the first full-time Director for the Women Veterans Health Program. The program provides a comprehensive system of cost-effective medical and psychosocial services for women. In addition to preventive services, the high quality medical services available to women veterans include primary care, gender-specific care, reproductive health care, and evaluation and treatment for osteoporosis. In 1999, the uniform benefits package included a maternity care benefit for women veterans as well as infertility evaluation and limited treatment.

Issue 23

Lack of pre-, during-, and post-deployment education tools and support to service members and their families.

Recommendation

Consistent and mandatory national standards of information for DOD and DVA to present to every service member. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs.

Sponsorship/Mentorship programs must be established and assigned to service members to offer communication and support regarding military experiences. This is an action item for the Departments of Defense and Homeland Security.

Family network and support groups must be improved and promoted nationally and locally. This is an action item for the Departments of Defense and Homeland Security.

Rationale

There are sources available for this information now. These include Army Family Online at http://www.armyfamiliesonline.org/skins/WBLO/home.aspx?AllowSSL=true; Marine Corps Community Services at http://www.usmc-mccs.org/ and Military Advantage at http://images.military.com/Content/MoreContent1/0,,Deployment_Center,00.html to just to point out a few. However, standardization and ease of access are not a factor in finding the information nor acquiring access to it.

Issue 24

Service members are not being enrolled in the VA system.

Recommendation

Mandatory and automatic enrollment. This is an action item for the Departments of Defense, Homeland Security, and Veteran Affairs.

Rationale

In accordance with Public Law 100-527 and Department of Defense Instruction 1336.1, Copy 3 of the service members DD-214 is forwarded to the USDVA Data Processing Center in Austin, TX. A reproduced copy of Copy 3 is forwarded, along with the service member's medical records, to the DVA medical facility if the service member is transferred to the VHA for health care. If the service member completes a VA Form 21-526, Application for Compensation and/or Pension, a copy of Copy 3, along with the medical records, will go to the VA Regional Office (VARO) having jurisdiction. Copy 6 may go to the State Director of Veteran Affairs if the service member requests it. Copy 3 is retained by the service if the member re-enlisted.

There is, unfortunately, no sure way for the Personnel Support Activity to know if the member has applied for VA Compensation, therefore the DD-214 and Medical Records probably do not go to the VARO of jurisdiction.

As USDVA does have Copy 3 of the DD-214, automatic enrollment for DVA healthcare should not be a difficult task.

Issue 25
Post-deployment briefings are ineffective.

Recommendation

More time allowed between return and briefing times. This is an action item for the Departments of Defense, Homeland Security, Labor, and Veterans Affairs.

Upon automatic VA enrollment, the VA must perform a follow-up every six months for a 24 month period. This is an action item for the Department of Veterans Affairs.

Rationale

Steering Committee Note: Time between return of a unit and post-deployment briefings appears to be a command function and may be based on unit operational or training commitments.

Issue 26
Lack of a central referral agency.

Recommendation

Utilize local veteran service organizations, such as AMVETS. This is an action item for the National Association of County Veterans Service Officers and the Veterans Service Organizations.

Steering Committee Note: The following recommendation was addressed under Issue 4 of this chapter.

Full-time position as a family support representative in each unit to function as a referral agency. This is an action item for the Departments of Defense and Homeland Security.

Rationale

Local County Veteran Service Offices, State Department of Veteran Affairs Field Service Offices, and local Posts and Chapters of Veteran Service Organizations should, and many already do, provide this service.

Issue 27
Sexual trauma/sexual harassment can cause Post Traumatic Stress Disorder.

Recommendation

Steering Committee Note: All items in this issue have been addressed as Issue 19 of this chapter.

Require sexual assault response coordinator to brief service members during down time prior to deployment at mobilization sites.

Ensure a certified unit representative in the field is present.

Medical evidence of the incident should be provided to the service member.

Issue 28
Information/latest news not being disseminated to VAMCs/clinics.

Recommendation

Provide latest information on Web site, CDs and hotlines. This is an action item for the US Department of Veterans Affairs.

Rationale

Steering Committee Note: The Steering Committee believes that the USDVA Veterans Health Administration does provide the latest information and news to all 400+ facilities under its cognizance. Whether or not the facility director or manager is disseminating the information is an internal manner and the Under Secretary of Health should reaffirm his position with his subordinates.

Issue 29

Seamless Transition is not consistently available throughout VAMCs and military installations.

Recommendation

Steering Committee Note: The USDVA Veterans Benefits Administration maintains Veteran Service Representatives at all VA Medical Centers and all military installations participating in the Transition Assistance Program. As such we do not intend to pursue this recommendation at this time.

Dedicated full-time position at every VAMC and military installation. This is an action item for the US Department of Veterans Affairs.

Steering Committee Note: The following recommendation is discussed as Issue 24 of this chapter.

With veterans consent, provide medical eligibility from DOD to VA. This is an action item for the US Department of Veteran Affairs.

Issue 30
Inadequate follow-up with medical/mental health.

Recommendation

Steering Committee Note: This issue was discussed as Issues 5 and 7 of this chapter.

More staff and training and expand operational hours. This is an action item for the US Department of Veteran Affairs, it also has budgetary ramifications.

Timely notification of appointments; more effective communications. This is an action item for the US Department of Veterans Affairs.

Issue 31
Sensitivity to veterans' needs.

Recommendation

Sensitivity/Customer Service training. This is an action item for the US Department of Veteran Affairs.

Accountability for actions. This is an action item for the US Department of Veteran Affairs.

Rationale

Steering Committee Note: This issue was discussed as Issue 5 of this chapter.

Issue 32
Lack of knowledge of some internal/external services.

Recommendation

Increase participation with external services and educate through mandated staff training. This is an action item for the US Department of Veterans Affairs.

Rationale

The Government Employees Training Act (GETA) became law in 1958 giving Federal agencies general authority for employee training. Among its many provisions, this law authorized the use of non-Government training resources to meet identified training needs which otherwise could not be met with existing Governmental programs and facilities. Amended in 1994, the Act permits agencies to take advantage of the existing training marketplace, Government or non-Government. Section 2 of the Act states: "It is necessary and desirable in the public interest that self-education, self-improvement, and self-training be supplemented and extended by Government-sponsored programs for the training of such employees in the performance of official duties and for the development of skills, knowledge, and abilities which will best qualify them for performance of official duties … such programs shall be designed to lead to … the building and retention of a permanent cadre of skilled and efficient Government employees well abreast of scientific, professional, technical, and management developments both in and out of Government…"

Issue 33
Lack of critical staff.

Recommendation

Active marketing of scholarship for critical staff (i.e. psychology and vocational rehabilitation). This is an action item, with budgetary implications, for the US Department of Veteran Affairs.

Rationale

Scholarship For Service (SFS) is a unique program designed to increase and strengthen the cadre of federal information assurance professionals that protect the government's critical information infrastructure. This program provides scholarships that fully fund the typical costs that students pay for books, tuition, and room and board while attending an approved institution of higher learning. Additionally, participants receive stipends of up to $8,000 for undergraduate and $12,000 for graduate students. This appears to be an outstanding program for IT professionals employed by the Federal government and additional information may be acquired through the Office of Personnel Management. However, it begs the question, if we're willing to educate those who protect the government's critical information infrastructure, shouldn't we be willing to educate those who assist the government's most important asset, people?

Issue 34
Veterans do not understand what Vocational Rehabilitation can offer.

Recommendation

Marketing strategy that targets and attracts younger veterans. This is an action item for the US Department of Veterans Affairs.

Rationale

This is a difficult issue, at best. The Department of Veterans Affairs Office of Public and Intergovernmental Affairs should partner with the Vocational Rehabilitation and Employment Program and use known entities to tell the young veteran about VR&E programs. These could include men and women like MAJ Tammy Duckworth, SFC Dana Bowman, SGT of Marines James Wright or some of the competitors in the National Disabled Veterans Winter Sports Clinic in Televised Public Service Announcements.

Issue 35
Stigma associated with VA.

Recommendation

VA service centers modeled after military recruitment centers. This is an action item for the US Department of Veterans Affairs.

Overlap between DOD, DVA, and VSO while service members are on active duty. This is an action item for the Departments of Defense, Homeland Security, and Veterans Affairs and the Veterans Service Organizations.

Rationale

The stigma attached to the USDVA is, for the most part, generated by the news media only telling about the negative activities within the department and not the positive activities. Because of the items covered by the media, many young veterans feel that DVA is designed for the elderly. USDVA has no control over what information the media publishes, but, they do have control over how the public perceives the DVA facilities. Many of them are quite old, and while historic and beautiful, they are often somewhat rundown. VR&E offices could be shifted from the VARO and into storefront operations in malls like many of the military recruiting offices. That could attract both the disabled veteran that requires VR&E services as well as the employer who desires a skilled work force.

The second recommendation appears to point out many incongruities between the organizations mentioned. The Department of Defense faces the key issue of retention of it's highly trained military personnel on a daily basis. They sometimes feel that the main mission of some Department of Veterans Affairs activities is to show the service member the benefits they would receive if they were NOT a member of the Armed Forces. At the same time, some Veterans Service Organizations, in the past, have used access to military installations as a ploy to sell certain products to service members. Both of these thoughts were true, once, but they are not true today. The DVA is interested in telling the service member what benefits they will receive when they leave the military, whether it's voluntary or involuntary, at the completion of their initial enlistment or at the end of a 30-year career. The VSOs, on the other hand, do not have a "product" to sell. They are not-for-

profit, membership driven, organizations that provide a service to the veteran and the military service member. They do actively recruit military personnel, true, but in most instances the VSO provides the service member with a free membership. The primary purpose of VSO personnel on a military installation is to assist the service member who is leaving the military with the filing of any necessary claims for benefits from the USDVA.

Issue 36
Community lack of awareness of VA purpose and services.

Recommendation

Repeal the law of no VA advertising. This is an action item for Congress.

Steering Committee Note: The following recommendation has been covered in Issues 32, 33, and 34 of this chapter.

Education and Marketing. This is an action item for the US Department of Veteran Affairs.

Rationale

Steering Committee Note: To the best of our knowledge there are no statutes or regulations that preclude the USDVA from advertising or marketing its services to the veteran community. There have been, in the past, intra-agency directives that have precluded this, but we can find no evidence of such directives in force now. The Office of the Assistant Secretary for Public and Intergovernmental Affairs is specifically funded to provide veterans and their dependents information through the news media about USDVA benefits and programs.

NATIONAL HEADQUARTERS
4647 Forbes Blvd.
Lanham, Maryland 20706
(301) 459-9600
Fax: (301) 459-7924
amvets@amvets.org

www.amvets.org